

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 to be retained by the hospital or attending physician and completely filled in by the funeral director. Page 2 of 3 to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

80

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02368

02355

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 21 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTON Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First Magdelene Middle Adams Last		4. DATE OF DEATH 2 - 11 1962		5. SEX Female		6. COLOR OR RACE Col.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-17-1917		9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Johnson				14. MOTHER'S MAIDEN NAME Isabell Lewis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mary E. Adams Ridgely, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Enter cranial hemorrhage 204.3 DUE TO Thrombocytopenia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Acute myelogenous leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Carcinoma of the cervix							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 Dec 1961 to 11 Feb 1962 , that (I) (we) last saw the deceased alive on 11 Feb 1962 , and that death occurred at 12 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Thurston Harrison M.D.				22b. DATE SIGNED 12 Feb 62		22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON	
22d. ADDRESS Easton, Maryland				22e. REGISTRAR'S SIGNATURE Charles L. Kline			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-14-62		23c. NAME OF CEMETERY OR CREMATORY Mission		23d. LOCATION (City, town or county) (State) Ridgely, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Boulais ADDRESS Baltimore, Md				25a. REC'D BY REGISTRAR FEB 15 '62		25b. REGISTRAR'S SIGNATURE	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02336											
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>13 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>29 EASTON</u> d. STREET ADDRESS <u>1 225 Port</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>MARY</u> <u>M.</u> <u>Allen</u>					4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>1962</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 16, 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John H. Miller</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or Unknown) <u>NO</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Dorothy Reddick Easton, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation - Smoke</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House burned</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>5:30</u> p.m. <u>2-3</u> <u>1962</u>					20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>225 Port St Easton Talbot</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Lewis Welch</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>WELCH</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					Address (Street, city, town, or county) <u>225 Port St Easton Talbot</u>						
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
<u>Burial</u>		<u>2-8-62</u>		<u>Calvary Cem.</u>		<u>Norfolk, Md.</u>					
23. FUNERAL DIRECTOR <u>James D. Dostie, Easton, Md.</u>					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
					DATE <u>FEB 8 '62</u>		<u>Clifford S. Evans</u>				

FILE NO.
1930

(M)

Infant

Female

1930

Infant

Female

1930

Infant

Female

Infant

Female

1930

Infant

Female

Infant

Female

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X

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Infant

Female

Infant

Female

1930

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VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02370

02357

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>29 Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL Hospital</u>			d. STREET ADDRESS <u>1 404 Winton Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert Oliver Chance</u>			4. DATE OF DEATH <u>2 15 19 62</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1927</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>weightmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>poultry factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Leslie R. Chance</u>			14. MOTHER'S MAIDEN NAME <u>Mildred E. Soulsby</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-16-3064</u>		17. INFORMANT <u>Mrs. Nancy Chance</u> <u>Easton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150X Metastatic adenocarcinoma of bones, lungs, & liver due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>adenocarcinoma of esophagus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., and that death occurred at 3:25 P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>			22b. DATE SIGNED <u>15 Feb 1962</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>			22d. ADDRESS <u>Easton, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 17, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Easton, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neumann & Son</u> <u>Easton, Md.</u>			
25a. REC'D BY REGISTRAR <u> </u>			25b. REGISTRAR'S SIGNATURE <u> </u>		

MEDICAL CERTIFICATION

(M)

05830

DEATH OF DEATH

US33

404 W. 1st St.
East

Dr. R. R. 1921 34

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W. R. 1921 F. 2000

312-12-306 Mrs. Mary Grace
M. R. 1921 F. 2000
Jones, J. R. 1921 F. 2000
M. R. 1921 F. 2000

E. C. H. Schmidt
Pathologist

Journal for 1921 (1921) (1921)
M. R. 1921 F. 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02371

02358

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Easton		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. #4		d. STREET ADDRESS R.F.D. #4	
3. NAME OF DECEASED (Type or print) GERTRUDE DIXON DORSEY		4. DATE OF DEATH Month Feb. 6, Day 19 Year 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1902
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Isaac H. Dixon		14. MOTHER'S MAIDEN NAME Elizabeth White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-24-7404	
17. INFORMANT Dr. John S. Green, III		Address Easton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 148X Carcinoma of the Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 148X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 18 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 5, 1962 , to 6 Feb. 1962 , that (I) (we) last saw the deceased alive on 5 Feb. 1962 , and that death occurred at 6 PM , from the causes and on the date stated above.			
22a. SIGNATURE Thurston Harrison		22b. DATE SIGNED 6 Feb 62	
22c. PHYSICIAN'S NAME (Type) Dr. Thurston Harrison		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1962	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		25a. REC'D BY REGISTRAR FEB 9 '62	
ADDRESS Easton, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

02331

02330

Subject

Subject

Subject

Initials

Initials

Initials

U.S.N. 44

U.S.N. 44

CONTINUING FROM PAGE

Page 5

Page 5

Location

Location

Location

Remarks

Remarks

Remarks

Personnel

Personnel

214-2-7404

214-2-7404

Mr. Thomas Harrison

Mr. Thomas Harrison

Butler, Wm. A. 1952

Butler, Wm. A. 1952

Butler, Wm. A. 1952

Harrison, Wm. A. 1952

Harrison, Wm. A. 1952

Harrison, Wm. A. 1952

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02372

02359

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>80 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>117 Dover St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>H. Fleckenstein</u> Middle <u>J.</u> Last				4. DATE OF DEATH <u>Feb</u> Month <u>14</u> Day <u>1962</u> Year			
5. SEX <u>Male</u>		6. COLOR OF SKIN <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 8, 1872</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Contractor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Leonard S. Fleckenstein</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Kauffman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) _____				16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Mrs. Oliver Mallin</u> Address <u>Easton Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm of abdominal aorta</u> 451X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>2-12</u> , <u>1962</u> , to <u>2-14</u> , <u>1962</u> , that (I) (we) last saw the deceased alive on <u>2-13</u> , <u>1962</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Travers</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-16-62</u>	
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 16/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		23d. LOCATION (City, town or county) <u>Easton</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Manue E. Newman</u> ADDRESS <u>Easton Md.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 20 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05350

05350

(M)

John
Carter

William
White

110 Grand St.

7th Street
St. Louis

PO

James P. Humphreys
James P. Humphreys
James P. Humphreys
James P. Humphreys

James P. Humphreys
James P. Humphreys

James P. Humphreys
James P. Humphreys

James P. Humphreys
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02373					02360						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
Talbot			EASTON		1 day		RURAL QUEENSTOWN 17X-2		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
George Henry Green					Feb 27 1962						
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DEC 25 1880		81 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Laborer				FARM		QUEEN ANNE'S MARYLAND			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
GEORGE GREEN					UNKNOWN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address				
No					NONE		Mrs. BESSIE GREEN, QUEENSTOWN, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure										Unknown	
4200 DUE TO (b) Arteriosclerotic heart disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Cerebral arteriosclerosis, Chronic brain syndrome											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from 2-26 1962 to 2-27 1962 that (I) (we) last saw the deceased alive on 2-27 1962, and that death occurred at 8:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Trever					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		2/28/62 DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Robert W. Trever					M.D.		22d. ADDRESS Easton, Md.		2/28/62		
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			MAR. 7, 1962		CARMICHAEL CEMETERY			RURAL QUEENSTOWN, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James H. Bailey, Jr. of Burton Bros., Centerville, Md.							DATE MAR 5 '62		Charles L. Harris		

M

02373

02373

REPUBLIC OF CHINA

THE PRESIDENT OF THE REPUBLIC OF CHINA

THE VICE PRESIDENT OF THE REPUBLIC OF CHINA

THE MINISTER OF THE INTERIOR

THE MINISTER OF JUSTICE

THE MINISTER OF EDUCATION

THE MINISTER OF AGRICULTURE

THE MINISTER OF FINANCE

THE MINISTER OF TRANSPORTATION

THE MINISTER OF CONSTRUCTION

THE MINISTER OF SOCIAL AFFAIRS

THE MINISTER OF HEALTH

THE MINISTER OF LABOR

THE MINISTER OF ENVIRONMENTAL PROTECTION

THE MINISTER OF SCIENCE AND TECHNOLOGY

THE MINISTER OF CULTURE

THE MINISTER OF SPORTS

THE MINISTER OF TOURISM

THE MINISTER OF RELIGION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02374

02381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>4 HRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>EASTON MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>29 EASTON</u> d. STREET ADDRESS <u>1 PROSPECT AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEWIS SETH GREEN</u> First Middle Last				4. DATE OF DEATH <u>FEBRUARY 9 1962</u> Month Day Year			
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 28 1924</u> Yrs. Months Days Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLUB MANAGER</u> 11b. KIND OF BUSINESS OR INDUSTRY <u>TALBOT COUNTRY CLUB</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM GREEN</u>				14. MOTHER'S MAIDEN NAME <u>JESSIE MARSHALL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-126390</u> 17. INFORMANT <u>MRS. FLAINE T. GREEN</u> Address <u>EASTON, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, right</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 8:35 PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>E. C. H. Schmidt</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				22b. DATE SIGNED <u>10 Feb 62</u> 22d. ADDRESS <u>Easton Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/12/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEMETERY</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Hampton</u>		24b. ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>William S. Kraus</u>			
25b. REGISTRAR'S SIGNATURE		DATE <u>FEB 13 '62</u>					

1082

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02375 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02362

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland. b. COUNTY Talbot			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton,		c. LENGTH OF STAY IN 1b 9 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 29 Easton.		d. STREET ADDRESS 1 102 Prospect St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 102 Prospect Street.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Estelle B. Hickman				4. DATE OF DEATH Month Day Year Feb. 25, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1887	
9. AGE (in years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Own home.		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry William Brashears.				14. MOTHER'S MAIDEN NAME Laura May Smith.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-67-8374		17. INFORMANT Address same as above Mrs. Fleetwood E. Carlson Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (Christian Scientist - bedridden yrs at home)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis J. Kelly KELTY				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 2-25-62			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF Feb. 26, 1962		22c. NAME OF CEMETERY OR CREMATORY Selwyn Cemetery	
				22d. LOCATION (City, town, or country) Baltimore, Delaware		(State)	
23. FUNERAL DIRECTOR Robert E. Easton, Md.				24a. REC'D BY REGISTRAR FEB 28 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2560



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02363**

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Longwoods c. LENGTH OF STAY IN 1b 29 Easton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Judas St.	
3. NAME OF DECEASED (Type or print) JUSTON MELVIN JOHNSON		4. DATE OF DEATH Month Feb. Day 22, Year 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1907
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) service station operator		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
11c. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Johnson		14. MOTHER'S MAIDEN NAME Susie M. Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-8046	
17. INFORMANT Mrs. Helen Johnson		Address Easton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gun shot wound-head, self inflicted 976X DUE TO 22 rifle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) suicide	
20c. TIME OF INJURY Month, Day, Year 1:45 P.M. Feb. 22, 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) sand pit		20f. (City or town) (County) (State) rural Longwoods, Talbot, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Thurston Harrison		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Thurston Harrison		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 1962	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		22d. LOCATION (City, town, or county) (State) rural Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE 2 6 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02377

02364

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Claiborne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Maryland</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Melville Kelsor, SR.</u>		4. DATE OF DEATH <u>Feb 6 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Methodist Church</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Kelser</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Potter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>218 10 0699</u>	
17. INFORMANT <u>Miss Nettie Jones, Claiborne, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> (b) <u>atherosclerotic obstructive coronary artery</u> (c) <u>Renal arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>2-6</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2-6</u> , 19 <u>62</u> , and that death occurred at <u>2-6</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Guy M. Reeser, Jr.</u> M.D.		22b. DATE SIGNED <u>2-6-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Guy M. Reeser, Jr. M.D.</u>		22d. ADDRESS <u>St. Michaels, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Easton Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Frampton Carroll</u>		25a. REC'D BY REGISTRAR <u>FEB 13 '62</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02378

CERTIFICATE OF DEATH

02365

Item 7 Film G308 3/1/62 ink

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MD. b. COUNTY Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 3 1/2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTON Memorial Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Trappe	
3. NAME OF DECEASED (Type or print) Ida First MARSHALL Middle Leonard Last		4. DATE OF DEATH February 21 1962 Month February Day 21 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME JAMUEL B. Marshall		14. MOTHER'S MAIDEN NAME Mary L. Blades	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO myocardial infarction (severe) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Heart Disease (c) 10 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-21 , 1962, to 2-21 , 1962, that (I) (we) last saw the deceased alive on 2-21 , 1962, and that death occurred at Easton , from the causes and on the date stated above.			
22a. SIGNATURE William L. Winters M.D.		22b. ADDRESS 210 E DOVER, EASTON MD.	
22c. PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS		22d. ADDRESS 210 E DOVER, EASTON MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 24, 1962	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town or county) (State) Easton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marion E. Newman		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. DATE FEB 26 '62	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02379						02366					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Talbot			EASTON			Maryland			Caroline		
c. LENGTH OF STAY IN lb			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. STATE			f. COUNTY		
10 hrs - 35 min			Memorial Hospital Inc.			Denton			05 X 2		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
William Edward Magness						Feb 2 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
M		W		NEVER MARRIED		JAN. 10, 1885		77 yrs.		IF UNDER 24 HRS.	
				WIDOWED						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Day LABORER								DELAWARE			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JOHN MAGNESS						JOSEPHINE GLADSTONE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT						Address					
Mrs W. W. Magness, Denton, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pneumonia, bilateral											
DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
DUE TO											
(c), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on Feb 2 1962, and that death occurred at 5:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
22e. REC'D BY REGISTRAR											
22f. REGISTRAR'S SIGNATURE											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE											
24a. ADDRESS											
24b. REC'D BY REGISTRAR											
24c. REGISTRAR'S SIGNATURE											

05300

CERTIFICATE OF DEATH

05300

(M)

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, read in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02380		Items 8 & 9 Film G308 3/1/62 iwk				02367					
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>				c. LENGTH OF STAY IN 1b <u>Life</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 100 Route 2</u>				d. STREET ADDRESS <u>Box 100 Rt 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Addie</u> First <u>McDaniel</u> Middle <u>McDaniel</u> Last				4. DATE OF DEATH <u>2</u> Month <u>17</u> Day <u>1962</u> Year							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1885</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Robert Wilson</u>						14. MOTHER'S MAIDEN NAME <u>MARY Bently</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>919-14-2645</u>		17. INFORMANT <u>MARY EASON - TRAPPE, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>arteriosclerosis</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis secondary to Plasma Cell Myeloma</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>2/18</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>58</u> , to <u>2/17</u> , 19 <u>62</u> ; that (I) (<u>two</u>) last saw the deceased alive on <u>2/18</u> , 19 <u>62</u> , and that death occurred at <u>7:30 A</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>L. J. Eglseider</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>L. J. Eglseider</u> 22d. ADDRESS <u>Easton, Md.</u> 23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-15-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Trappe, Cam</u> 23d. LOCATION (City, town or county) (State) <u>Trappe Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Doshell, Easton, Md.</u> ADDRESS <u>Easton, Md.</u> 25a. REC'D BY REGISTRAR <u>Feb 27 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Hines</u>											

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FOR STATE HEALTH DEPT. (M)
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
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VS. A15ME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02368

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) <u>MARYLAND</u> b. COUNTY <u>CHARLOTTE</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PRESTON</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GOLDSBORO</u> <u>05x-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MBMORTAL Hosp</u>			d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>REBECCA ELLEN McMULLEN</u>			4. DATE OF DEATH Month Day Year <u>FEB 21 1962</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 9, 1901</u>		9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ALEXANDER GRIFFITH</u>			14. MOTHER'S MAIDEN NAME <u>ELLA BOOKER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>WM. McMULLEN, GOLDSBORO, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis -</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH <u>24 hr - several yrs -</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-24-62</u> ACTUAL SIGNATURE <u>Dawson D. George</u> M.D. EXAMINER'S NAME (Type) <u>DAWSON D. GEORGE</u> Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>	
23. FUNERAL DIRECTOR ADDRESS <u>Virgil Hoover Denton</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 28 '62</u>		
			24b. REGISTRAR'S SIGNATURE <u>Carlton S. Foxworth</u>		

3658



02382

CERTIFICATE OF DEATH

02369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RIO-VISTA NURSING HOME</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE V. MULDOON</u>		4. DATE OF DEATH Month Day Year <u>FEB 28 1962</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14-1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID PATTERSON</u>		14. MOTHER'S MAIDEN NAME <u>META L. THOMPSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>DR. RALPH MULDOON CHESTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonitis</u> DUE TO (b) <u>influenza</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cardiac failure, cachexia, multiple myeloma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 w 6 d</u> <u>1 w 6 d</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1961</u> , 19 <u>62</u> to <u>2-28</u> , 19 <u>62</u> that I last saw the deceased alive on <u>2-28</u> , 19 <u>62</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guy M. Reeser</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3-1-62</u>	
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR. 2</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MAPLE WOOD</u>	22d. LOCATION (City, town, or county) (State) <u>FREEHOLD N. J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Fries</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

05002

(M)

05002

1. Name of Deceased: *JOHN J. SMITH*
2. Sex: *Male*
3. Age: *45*
4. Date of Birth: *1910-10-15*
5. Date of Death: *1955-11-20*
6. Place of Death: *Home*
7. Cause of Death: *Myocardial Infarction*
8. Duration of Illness: *2 weeks*
9. Name of Physician: *Dr. J. H. Jones*
10. Name of Attending Nurse: *Miss A. B. White*
11. Name of Coroner: *Mr. C. D. Green*
12. Name of Registrar: *Mr. E. F. Black*
13. Name of Burial Place: *St. Mary's Cemetery*
14. Name of Minister: *Rev. W. L. Brown*
15. Name of Undertaker: *Mr. G. H. White*
16. Name of Funeral Home: *St. Mary's Funeral Home*
17. Name of Cemetery: *St. Mary's Cemetery*
18. Name of Interment: *Interment*
19. Name of Burial Place: *St. Mary's Cemetery*
20. Name of Minister: *Rev. W. L. Brown*
21. Name of Undertaker: *Mr. G. H. White*
22. Name of Funeral Home: *St. Mary's Funeral Home*
23. Name of Cemetery: *St. Mary's Cemetery*
24. Name of Interment: *Interment*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 3 hrs. 20 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 EASTON, d. STREET ADDRESS 107 TRED AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EFFIE ELVA First Middle Last 4. DATE OF DEATH February 17 1962 Month Day Year		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JULY 16, 1895 9. AGE (In years lost birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) TALBOT MD 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES MARION TARR 14. MOTHER'S MAIDEN NAME MATTIE ELVA GARDNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT JEAN CLARENCE NORTH Address EASTON, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hypertension 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 17 Feb 1962 to 18 Feb 1962 that (I) (we) last saw the deceased alive on 18 Feb 1962 , and that death occurred on 18 Feb 1962 at 3:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Thurston Harrison 22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON		22b. DATE SIGNED 19 Feb 62 22d. ADDRESS Carby Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried 23b. DATE THEREOF Feb 9, 1962 23c. NAME OF CEMETERY OR CREMATORY Spring Hill 23d. LOCATION (City, town, or county) (State) Carby MD		24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hanna 25a. REC'D BY REGISTRAR FEB 21 '62 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

05340

MARY ANN
CHURCHILL
CARRIAGE CO. WASH.

05340

14



14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

02384

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02371

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLAIBORNE		MARYLAND c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLAIBORNE		d. STREET ADDRESS 11		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles First H. Middle Pinkney Last		4. DATE OF DEATH Feb. Month 15, Day 1962 Year											
5. SEX MALE		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1902		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY WATERMAN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Pinkney		14. MOTHER'S MAIDEN NAME Anna Brooks											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 226-091499		17. INFORMANT Opelia Pinkney -		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. hypertension (b) hypertension (c) hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic last 3 yrs										INTERVAL BETWEEN ONSET AND DEATH 7 mos 5 yrs 5 mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Feb 15, 1962 to Feb 15, 1962 that (I) (we) last saw the deceased alive on Feb 15, 1962 and that death occurred at 11 PM , from the causes and on the date stated above.													
22a. SIGNATURE GUY M REESER		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) GUY M REESER		22d. ADDRESS TILGHMAN Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 18, 1962		23c. NAME OF CEMETERY OR CREMATORY CLAIBORNE Cem.		23d. LOCATION (City, town, or county) CLAIBORNE		(State) Md.					
24. FUNERAL DIRECTOR'S SIGNATURE James Bradell		ADDRESS - Easton, Md.		25a. REC'D BY REGISTRAR Feb 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

023371

CERTIFICATE OF DEATH

388

(M)

Charles X. ...
1912 ...
Maryland ...
Anna Brooks ...
110 ...

(1)

1912 ...
Clarkson ...
110 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02385

02372

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Cordova		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 50		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle EDWARD Last Randolph Plugge		4. DATE OF DEATH Month February 2 Day Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming- Ret.		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Plugge		14. MOTHER'S MAIDEN NAME Catherine Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215 38 1320	
17. INFORMANT Mrs. Elizabeth G. Plugge, Cordova, RD, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute MYOCARDIAL INFARCTION DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 20, 1962 to Feb. 1, 1962, that (I) (we) last saw the deceased alive on Feb. 1, 1962 and that death occurred at 4 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Shepard Krech, Jr.		22b. DATE SIGNED Feb. 3, 1962	
22c. PHYSICIAN'S NAME (Type) Shepard Krech, Jr. M.D.		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/4/62	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Pk.		23d. LOCATION (City, town, or county) (State) Easton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Carroll		25a. REC'D BY REGISTRAR DATE FEB 6 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

05375

CERTIFICATE OF DEATH

05382

(M)

[Faint, mostly illegible text and signatures are visible in the lower half of the document, including what appears to be a signature in the bottom right corner.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02386

02373

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN IB <u>3 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CIAIBORNE</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HENRY "HARRY" BATEN RICHARDS</u>				4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1872</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>18</u> Min. <u>00</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEWARK MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>John B. Richards</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WILLIAMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>344-05-1031</u>		17. INFORMANT <u>Mrs. Olivia J. Richards, Claiborne Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> (b) <u>Myocardial infarction</u> (c) <u>Arteriosclerotic Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 wks</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9 Feb 1962</u> to <u>18 Feb 1962</u> , that (I) (we) last saw the deceased alive on <u>18 Feb 1962</u> and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R. L. WROTH</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. L. WROTH</u>				22d. ADDRESS <u>ST. MICHAELS, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-21-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hurlock, Ind</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hampton Harrison</u>				ADDRESS <u>St. Michaels, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 21 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02373

CERTIFICATE OF DEATH

23388

(M)

TALBOT
FAYTON

MEMORIAL HOSPITAL

HENRY HARRY BATES KINGS

WHITE

RETIRED

John B. Richards

ELIZABETH WILKINS

NEWARK MD U.S.A.

1942

ST. JOHN CHURCH, MD

R. L. WRIGHT

General - 2-1-40 Washington County, Maryland

Washington, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02387 02374

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>	
c. LENGTH OF STAY in 1b <u>55 min.</u>		d. STREET ADDRESS <u>05X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MURTIE</u> Middle <u>ROBINSON</u> Last <u>ROBINSON</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15, 1901</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAS. EDWARD HOLDEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MAY COVEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. John R. Robinson Denton, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20-1</u> DUE TO <u>Acute pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerotic heart disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>11 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>26 Feb</u> , 19 <u>62</u> , to <u>26 Feb</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>26 Feb</u> , 19 <u>62</u> , and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Thurston Harrison</u>		22b. DATE SIGNED <u>26 Feb 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>		22d. ADDRESS <u>Carlton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 28, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u>	23d. LOCATION (City, town or county) (State) <u>Centerville, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Woodward Denton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

(M)

53887

CERTIFICATE OF DEATH

05313

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

(M)

80

(I)

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02388						02375					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution, residence or before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			d. STREET ADDRESS		
TALBOT			EASTON			2 hrs. 45 min			Talbot		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			EASTON Memorial Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
Thomas Milton Saunders						Feb 2, 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	
male		white				June 24, 1878		83 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTH PLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer								Maryland		U.S.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Thomas Saunders						Angelina Dutcher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
no				219-03-4145		Harry Saunders				Tuppe Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis											
DUE TO (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
Month, Day, Year			While <input type="checkbox"/> Not While <input type="checkbox"/>								
Hour a.m. p.m.			at work <input type="checkbox"/> at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from 2-2-62 to 2-2-62, that (I) (we) last saw the deceased alive on 2-2-62, and that death occurred at 11:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type)		
Alfred J. Bartley						2-2-62			DONALD F. BARTLEY M.D.		
22d. ADDRESS						22e. DATE OF DEATH			22f. REGISTRAR'S SIGNATURE		
Easton						Feb 8 1962			Arthur S. Thomas		
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY			
Burial				Feb 5, 1962				Upper Bamberg			
23d. LOCATION (City, town or county)				23e. LOCATION (City, town or county)				23f. LOCATION (City, town or county)			
New Tuppe Md.				New Tuppe Md.				New Tuppe Md.			
24. FUNERAL DIRECTOR'S SIGNATURE						24b. REC'D BY REGISTRAR			24c. REGISTRAR'S SIGNATURE		
Maurice F. Neumann Son						FEB 8 1962			Arthur S. Thomas		

00000

CERTIFICATE OF DEATH

00000

(M)

James (son)

James (son)
born 1914
resided at 101st
St. Louis
Missouri
March 1914

James (son)
born 1914
resided at 101st
St. Louis
Missouri
March 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02389					02376				
Items 8 & 9 Film G307 2/15/62 iwk									
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			c. LENGTH OF STAY IN lb <u>5 hrs 35 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL Hospital</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HESTER MARIE TURNER</u>			First Middle Last		4. DATE OF DEATH <u>FEB. 7 1962</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 21, 1908</u>		9. AGE (In years last birthday) <u>53</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Andrew Barnett</u>					14. MOTHER'S MAIDEN NAME <u>Bertha Johnson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>218-09-7746</u>		17. INFORMANT <u>Kermit Turner, St Michaels, Md</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension, Essential</u> (c) <u>331X</u> DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>12 hrs</u> <u>3 years</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> 1962 to <u>2-7</u> 1962, that (I) (we) last saw the deceased alive on <u>2-6</u> 1962, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>R. Lane Wroth</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		1/7/62 DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>					M.D. 22d. ADDRESS <u>St. Michaels, Maryland</u>		1/7/62		
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>2-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Michaels Com.</u>		23d. LOCATION (City, town or county) <u>St. Michaels Md.</u> (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Deshield, Easton, Md.</u>					ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

(M)

02383

02383

Maryland
St. Michaels

Female (C)

seen

Maryland

Domestic

habitat

Bartholomew Johnson
Norman Johnson, St. Michaels, Md.

Andrew Barnett

Domestic

James D. Smith, St. Michaels, Md.
Trial 8-10-42 St. Michaels Com. St. Michaels

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02390

02377

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTON Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond	
3. NAME OF DECEASED (Type or print) First ROSA Middle Lee Last Wallace		d. STREET ADDRESS 14X-2	
4. DATE OF DEATH Month February Day 21 Year 1962		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1919
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 4 Days 14 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Caroline Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Satterfield		14. MOTHER'S MAIDEN NAME not known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Rev. R.T. Wallace Still Pond, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Coronary atherosclerosis heart disease (c) (Type underlying cause)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 Feb , 19 62 to 21 Feb , 19 62 , that (I) (we) last saw the deceased alive on 21 Feb , 19 62 , and that death occurred at 2:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Thurston Harrison M.D.		22b. DATE SIGNED 22 Feb 62	
22c. PHYSICIAN'S NAME (Type) THURSTON HARRISON		22d. ADDRESS Carlin, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/62	
23c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.		23d. LOCATION (City, town or county) (State) Still Pond, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Weller		24. ADDRESS Chestertown, Md.	
25a. REC'D BY REGISTRAR DATE FEB 27 '62		25b. REGISTRAR'S SIGNATURE Carlton S. Kenna	

02830

CERTIFICATE OF DEATH

02830



First

Married

Still born

3 days

Married

Age

Married

Married

Not known

Not known

Rev. R.T. White, Jr., D.D., M.D.

on

at

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02391

02378

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Easton R.T.D.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIOLA KATIE WARRICK</u>				4. DATE OF DEATH Month Day Year <u>FEB. 8 1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-06</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Blackwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-4338</u>		17. INFORMANT Address <u>Jawrita Warrick, Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetic Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> , 19 <u>59</u> to <u>2/8</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>62</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>L. J. ECLSEDER</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/9/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. J. ECLSEDER</u>				22d. ADDRESS <u>M.D. EASTON, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		23d. LOCATION (City, town or county) (State) <u>EASTON, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Blackwell, Easton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



1930

CERTIFICATE OF DEATH

08338

Franklin
Easton

1-27-00

Benjamin Gibson
Domestic
Maryland
Sophie Blackwell
Easton, Easton, Easton

Richardson
2-10-02
Easton

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02392 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02379											
1. PLACE OF DEATH a. COUNTY <u>TAIbot</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>MONTGOMERY</u> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN lb <u>26 hrs 2 min</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROGERS FORD</u> <u>75X-3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS <u>SOUTH LEWIS RD. BOX 438</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID</u>			First <u>ALVIN</u> Middle <u>WETTY</u> Last <u>WETTY</u>			4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 36, 1941</u>		9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u>	
										IF UNDER 24 HRS. Hours <u>20</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STUDENT</u>		11. BIRTHPLACE (State or foreign country) <u>CONNECTICUT</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Robert Alvin Wetty</u>						14. MOTHER'S MAIDEN NAME <u>MARY MAURER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>NELSON FUNERAL HOME</u>			Address <u>SPRING CITY PA.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>825X</u> <u>Captusent laceration of Rt lung</u> DUE TO <u>thorax</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>malignant interstitial & subpleural</u> DUE TO <u>emphysema & pulmonary thrombosis & abdominal wall</u> (c) <u>Complete atelectasis of Rt lung</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident, Driver hit in Right Shoulder</u>							
20c. TIME OF INJURY Month, Day, Year <u>Feb 1 1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rogers Ford</u>		20f. (City or town) <u>Pottstown</u>		(County) <u>Queens Anne Md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>C. R. Layton</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>C. R. Layton</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED <u>Feb 3, 1962</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF <u>FEB. 7, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND MEM. PARK</u>		22d. LOCATION (City, town, or country) (State) <u>POTTSTOWN PA.</u>	
23. FUNERAL DIRECTOR <u>NELSON FUNERAL HOME INC.</u>						ADDRESS <u>SPRING CITY PA</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 7 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. K...</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
05753



DATE OF DEATH: 10/10/1941
PLACE OF DEATH: 1000
DECEASED: 1000
CAUSE OF DEATH: 1000
MANNER OF DEATH: 1000
1000

1000
1000
1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02393		02380	
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>1</u>	
e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rio Vista Nursing Home</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John H. Whedbee</u>		4. DATE OF DEATH <u>Feb. 28, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 7, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Whedbee</u>		14. MOTHER'S MAIDEN NAME <u>Georgeanna C. Wiley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-36-2199</u>	
17. INFORMANT <u>Mrs. Katie H. Whedbee</u>		Address <u>Sherwood Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 4-80X DUE TO (b) <u>influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>atherosclerotic embolus cardio vas. d.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 WB</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic cardiac failure, Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-9-61</u> to <u>2-28</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>62</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. M. Reeser Jr.</u> M.D.		22b. DATE SIGNED <u>3-1-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. M. Reeser Jr.</u>		22d. ADDRESS <u>St Michaels Md</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>Mar 3, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. James Episcopal Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Newport Del.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Flewamy</u>		25a. REC'D BY REGISTRAR <u>5 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>			

(M)

02383

02383

William H. Wheeler
Federal Minister
Hotel Waverly
June 14, 1914
San Francisco, California

Dear Mr. Wheeler:
I am very glad to hear
from you and hope you
are well. I am still in
San Francisco.

Yours very truly,
Franklin D. Roosevelt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02394

02381

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>50 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 EASTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>121 S. HARRISON</u>			
3. NAME OF DECEASED (Type or print) First <u>J</u> Middle <u>McKenny</u> Last <u>Willis, Sr.</u>				4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES H. WILLIS</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA HARRIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-38-1063</u>		17. INFORMANT Address <u>J. McKENNEY WILLIS, JR. EASTON, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHD & Complete Heart Block -</u> <u>433.0</u> DUE TO <u>1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Insufficiency due to obstructed bladder</u> INTERVAL BETWEEN ONSET AND DEATH <u>16 days + 2 mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-2</u> , 19 <u>62</u> to <u>2-12</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>2-7</u> , 19 <u>62</u> and that death occurred at <u>8:55</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>William L. Winters</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>				22d. ADDRESS <u>210 E. DOVER EASTON MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Feb 4, 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Reef</u>		23d. LOCATION (City, town or county) (State) <u>Easton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kline</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02395 CERTIFICATE OF DEATH 02382

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN lb 65 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Easton Memorial Hospital		d. STREET ADDRESS DENTON	
3. NAME OF DECEASED (Type or print) First Wilmer Middle Edgar Last Willis		4. DATE OF DEATH Month Feb Day 13 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 5, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 6 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM WILLIS		14. MOTHER'S MAIDEN NAME NORMA LEE LAYTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wm. Willis, Denton Md.		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome; Mental retardation since birth DUE TO (c) Epilepsy		INTERVAL BETWEEN ONSET AND DEATH 2 mo. 2 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 12-10-61 , 19 12-13 , to 2-13 , 19 1962 that (I) (we) last saw the deceased alive on 2-13 , 19 1962 , and that death occurred at 8 A.M. from the causes and on the date stated above.
22a. SIGNATURE John E. Baybutt M.D.		22b. DATE SIGNED 2-15-62
22c. PHYSICIAN'S NAME (Type) John E. Baybutt, M.D.		22d. ADDRESS Easton Md
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Feb. 17, 1962	23c. NAME OF CEMETERY OR CREMATORY Denton
23d. LOCATION (City, town or county) (State) Denton, Md		24. FUNERAL DIRECTOR'S SIGNATURE W. H. Moor & Son ADDRESS Denton Md
25a. REC'D BY REGISTRAR FEB 20 1962		25b. REGISTRAR'S SIGNATURE William L. Frawley

05330

STATE OF TEXAS

05330

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
DEPARTMENT OF HEALTH
OFFICE OF THE HEALTH COMMISSIONER
DALLAS, TEXAS

Handwritten notes and signatures are visible throughout the page, including the name "J. Edgar Hoover" and various dates and initials. The text is mostly illegible due to the quality of the scan and the handwriting.